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Section

502.001: ~~Medical Benefit Request (MBR)~~Application for Benefits

(A) Filing an Application. To apply for MassHealth, a person or his or her ~~eligibility~~authorized representative must file ~~a Medical Benefit Request (MBR) at a MassHealth Enrollment Center or MassHealth outreach site. All members of the family group, as defined in 130 CMR 501.001, must be listed on the MBR whether or not they are applying for MassHealth.~~an application online at www.MAHealthConnector.org, complete a paper application, complete a telephone application, or apply in person at a MassHealth Enrollment Center (MEC).

(1) Online or Telephone Application Requirements.

(a) Individuals, or their authorized representative, if applicable, completing an application for MassHealth online at www.MAHealthConnector.org or by telephone must be identity proofed pursuant to 130 CMR 502.001(2). Eligibility based on an online or telephonic application cannot be determined until the identity is proven or a paper application is submitted.

(b) If an applicant submits a paper application or applies in person at a MassHealth Enrollment Center, identity proofing is not required.

(2) Identity Proofing Process. An individual or his or her authorized representative, if applicable, completing an online or telephonic application will be asked a series of questions to prove his or her identity.

(a) If the individual is successfully identity proofed, the application may be submitted and an eligibility determination will be performed.

(b) If the individual is not successfully identity proofed, the individual will be asked to provide one or two forms of acceptable documentation proving his or her identity. Documentation proving identity must be submitted to the MassHealth agency within 15 days from the date of the request.

(c) If identity proof is received within 15 days of the date of the notice referenced in 130 CMR 502.001(A)(2)(b), the eligibility process commences. The MassHealth agency will determine

(i) the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, and the eligibility start date is based on the date the application was received by the MassHealth agency; and

(ii) the need to request any corroborative information during the provisional eligibility period necessary to determine eligibility, as provided in 130 CMR 502.001(B), (C), and (D).

(d) If identity proof is not received within the 15 day period referenced in 130 CMR 502.001(A)(2)(b), the MassHealth agency will notify the applicant or his or her authorized representative that it is unable to determine eligibility for medical benefits. To apply for MassHealth, a new application must be submitted.

(e) Acceptable Documents for Identity Proofing. To prove his or her identity, an individual can submit the acceptable proofs of identity as described in 130 CMR 504.005(A)(3): *Acceptable Proof of Identity*.

(3) Paper Applications or In-Person Applications at the MEC Containing Missing or Inconsistent Information.

(a) If a paper application is received at a MassHealth Enrollment Center or a MassHealth outreach site and the applicant did not answer all required questions on the application or if the application is unsigned, the MassHealth agency is unable to determine the applicant's eligibility for MassHealth.

(b) The MassHealth agency requests responses to all of the unanswered questions necessary to determine eligibility. The MassHealth agency must receive such information within 15 days of the date of the request for the information.

(c) If responses to all unanswered questions necessary to determine eligibility are received within 15 days of the date of the notice referenced in 130 CMR 502.001(E)(2), the eligibility process commences. The MassHealth agency will determine

(i) the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, and the eligibility start date is based on the date the application was received by the MassHealth agency; or

(ii) the need to request any corroborative information during the provisional eligibility period necessary to determine eligibility, as provided in 130 CMR 502.001(B), (C), and (D).

(d) If responses to all unanswered questions necessary for determining eligibility are not received within the 15-day period referenced in 130 CMR 502.001(E)(2), the MassHealth agency notifies the applicant that it is unable to determine eligibility for medical benefits. The date that the incomplete application was received will not be used in any subsequent eligibility determinations.

(e) Inconsistent answers are treated as unanswered.

(B) Corroborative Information. The MassHealth agency requests all corroborative information necessary during the provisional eligibility period ~~to determine eligibility~~. The applicant must supply such information within ~~60~~90 days of the date of the Request for Information, as described at 502.003(C).

(C) Corroborative Information Received. If all necessary information is received~~, except verification of citizenship and identity, immigration status, or verification of a person's HIV-positive status,~~ within the ~~60~~90-day provisional eligibility period referenced in 130 CMR 502.00~~31~~(E~~B~~), the MassHealth agency will determine the ~~MBR is considered complete. The completed MBR activates the MassHealth eligibility process for determining the coverage type providing the~~ most comprehensive medical benefits for which the applicant is eligible.

(D) Corroborative Information Not Received. If the necessary information is not received within the ~~60~~90-day provisional eligibility period referenced in 130 CMR 502.00~~31~~(E~~B~~), the MassHealth agency notifies the applicant of the ~~deactivation of the MBR~~termination of benefits.

~~(E) Missing or Inconsistent Information on the MBRApplication.~~

~~(1) If an MBRpaper application is received at a MassHealth Enrollment Center or a MassHealth outreach site and the applicant did not answer all required questions on the MBRapplication, the MassHealth agency is unable to determine the applicant's eligibility for MassHealth.~~

~~(2) The MassHealth agency requests responses to all of the unanswered questions necessary to determine eligibility. The MassHealth agency must receive such information within 14 15 days of the date of the request for the information.~~

~~(3) If responses to all unanswered questions necessary to determine eligibility are received within 14 days of the date of the notice referenced in 130 CMR 502.001(E)(2), the MBRapplication activates the MassHealth eligibility process for determining~~

~~(a) the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, based on the date the MBR was received by the MassHealth agency; or~~

~~(b) the need to request any corroborative information necessary to determine eligibility, as provided in 130 CMR 502.001(B), (C), and (D).~~

~~(4) If responses to all unanswered questions necessary for determining eligibility are not received within the 1415 day period referenced in 130 CMR 502.001(E)(2), the MassHealth agency notifies the applicant that it is unable to determine eligibility for medical benefits. The date that the incomplete MBRapplication was received will not be used in any subsequent eligibility determinations.~~

~~(5) Inconsistent answers are treated as unanswered.~~

502.002: Reactivating the ~~Medical Benefit Request~~Application

~~Except as provided in 130 CMR 501.003(E), i~~If all required information is received by the MassHealth agency after the ~~60-day~~ period described in 130 CMR 502.001(D), or after a denial of eligibility, the MassHealth agency reactivates the ~~MBR~~application and considers it submitted as of the date the information is received, and the medical coverage date is established in accordance with 130 CMR 502.006. A new ~~MBR~~application must be completed if all required information is not received within one year of receipt of the previous ~~MBR~~application.

502.003: ~~Presumptive Eligibility for Children~~Verification of Eligibility Factors

The MassHealth agency requires verification of eligibility factors including income, residency, citizenship, immigration status, and identity as described in 130 CMR 503.000: *Health Care Reform: MassHealth: Universal Eligibility Requirements*, 504.000: *Health Care Reform: MassHealth: Citizenship and Immigration*, and 506.000: *Health Care Reform: MassHealth: Financial Requirements*.

~~(A) The MassHealth agency may determine a child presumptively eligible for either MassHealth Standard or MassHealth Family Assistance based on the family group's self-declaration of gross income. A child may be presumptively eligible for medical benefits under Family Assistance only if he or she does not have health insurance.~~

~~(B) Coverage for services under Presumptive Eligibility begins on the 10th day before the date the MassHealth agency receives the Medical Benefit Request. Presumptive Eligibility coverage ends 60 days from the begin date, or when the MassHealth agency makes an eligibility determination, whichever is earlier.~~

~~(C) A child may receive Presumptive Eligibility only once in a 12-month period.~~

(A) Information Matches. The MassHealth agency initiates information matches with other agencies and information sources as described at 130 CMR 502.004 in the following order, when an application is received in order to verify eligibility

(1) the Federal Data Hub, which matches with the Social Security Administration, the Department of Homeland Security, and the Internal Revenue Service; and

(2) state agencies and informational services.

(B) Electronic Data Sources. If electronic data sources are unable to verify or are not reasonably compatible with the attested information, additional documentation will be required from the individual.

(C) Request for Information Notice. If additional documentation is required, a Request for Information Notice will be sent to the applicant listing all requested verifications and the deadline for submission of the requested verifications.

(D) Time Standards. The following time standards apply to the verification of eligibility factors.

(1) The applicant or member has 90 days from the date of the Request for Information Notice to provide all requested verifications.

(2) If the applicant or member fails to provide verification of information within 90 days of the MassHealth agency's request, MassHealth coverage is denied or terminated.

(a) If the required verifications are received within one year from the date of the application or renewal form was received, coverage is reinstated to a date 10 days prior to the receipt of the verifications.

(b) If the required verifications are not received within one year of receipt of the previous application or renewal form, a new application must be completed.

(E) Provisional Eligibility. The MassHealth agency will provide benefits for up to 90 days, while the applicant provides ~~to~~ the MassHealth agency outstanding corroborative information. Except as further set forth below, the MassHealth agency will accept self-attestation for all eligibility factors other than citizenship and immigration status, and make a~~n~~ provisional eligibility determination as if the applicant had supplied the information. MassHealth applicants can receive only one provisional eligibility approval during a 12-month period. MassHealth members are required to enroll in managed care during the 90-day period, if enrollment is otherwise required as described in 130 CMR 508.004. MassHealth members who have been assessed a premium are subject to payment of premiums during the 90-day period. Premium assistance is not awarded during the 90-day period. It is only provided when all corroborative information has been received and the health-insurance investigation is complete, as described in 130 CMR 505.000. Provisional eligibility is subject to the following limitations:~~.~~

(1) The MassHealth agency will not accept self-attestation of disability. Disability must be verified as described in 130 CMR 505.002(E)(1): *Disabled Adults*.

(2) A member's coverage type will not be redetermined during the provisional eligibility period, except that members granted provisional eligibility who attest to pregnancy will be enrolled in MassHealth Standard.

(F) Reasonable Opportunity to Verify Citizenship and Identity or Immigration Status. The MassHealth agency provides applicants and members a reasonable opportunity period to provide satisfactory documentary evidence of citizenship and identity or immigration status if MassHealth's electronic data matches are unable to verify the applicant's citizenship or immigration status. The reasonable period begins on, and will extend 90 days from, the date on which an applicant or member receives a reasonable opportunity notice.

(G) Reasonable Opportunity Extension. Applicants or members who have made a good faith effort to resolve inconsistencies or obtain verification of citizenship and identity or immigration status may receive a 90-day extension. Requests for a reasonable opportunity extension must be made before the expiration of the verification time period.

(H) Hospital Determined Presumptive Eligibility.

(1) Presumptive Eligibility Determinations. A qualified hospital may make presumptive eligibility determinations for its patients in accordance with 450.110. Presumptive eligibility will be determined based on attested information. The qualified hospital may determine presumptive eligibility for the following:

(a) MassHealth Standard if the individual meets categorical and financial requirements in 130 CMR 505.002: *MassHealth Standard* and the individual is

(i) a child under the age of 1;
(ii) a child aged 1 through 18;
(iii) a young adult aged 19 to 20;
(iv) a pregnant woman;
(v) a parent or caretaker relative;
(vi) an individual with breast or cervical cancer;
(vii) an individual who is HIV positive; and
(viii) independent foster care children up to age 26.

(b) MassHealth CarePlus if the individual meets categorical and financial requirements in 130 CMR 505.008: *MassHealth CarePlus* and the individual is an adult aged 21 to 64.

(c) MassHealth Family Assistance if the individual meets categorical and financial requirements in 130 CMR 505.005: *MassHealth Family Assistance* and is

(i) an individual who is HIV positive; or
(ii) a child who is a non-qualified PRUCOL as described in 130 CMR 504.003(C) : *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs).*

(2) Coverage Start Date. Benefits provided through the hospital presumptive eligibility

process will begin on the date that the hospital determines presumptive eligibility and will continue until the sooner of

(a) the end of the month following the month in which the hospital determined presumptive eligibility, or

(b) an eligibility determination is made based upon the individual's submission of a complete application as described in 130 CMR 502.001.

(3) Premium Assessment. Individuals who are determined eligible through hospital-determined presumptive eligibility will not be assessed a premium. Premium assistance is not awarded during the presumptive eligibility period.

(4) Continued Eligibility. The individual must submit a complete application as described in 130 CMR 502.001 to determine continued eligibility for MassHealth.

502.004: Matching Information

The MassHealth agency may initiate~~s~~ information matches with other agencies and information sources when an application~~MBR~~ is received, at annual renewal and periodically, in order to update or verify eligibility. These agencies and information sources may include, but are not limited to, the following: the Federal Data Services Hub, the Division of Unemployment Assistance, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans' Services, Department of Revenue, Bureau of Special Investigations, ~~Internal Revenue Service,~~ Social Security Administration, ~~Alien Verification Information System~~Systematic Alien Verification for Entitlements, Department of Transitional Assistance**,** and health insurance carriers.

502.005: Time Standards for an Eligibility Determination

(A) For applicants who do not apply on the basis of a disability, the MassHealth agency makes an eligibility determination:

(1) within 60 days from the date of receipt of the complete ~~MBR~~application if the applicant is potentially eligible for MassHealth Family Assistance; or

(2) within 45 days from the date of receipt of the complete application~~MBR~~ for all other nondisabled applicants.

(B) For applicants who apply on the basis of a disability, the MassHealth agency makes an eligibility determination within 90 days from the date of receipt of the complete application~~MBR~~.

(C) Households with one or more applicants aged 65 or older who are not eligible for benefits under the regulations in 130 CMR 501.000: *Health Care Reform: MassHealth: General Policies* through 508.000: *Health Care Reform: MassHealth: Managed Care Requirements* will be determined by the time standards described at 130 CMR 516.004: *Time Standards for Eligibility Determination* for the entire household.

(D) The time standards described in 130 CMR 502.005(A) through (C) may be extended by the amount of time used by the applicant to respond to requests for additional information needed to make the disability determination.

502.006: Coverage Dates

(A) Start Date of Coverage. The date of coverage for MassHealth is determined by the coverage type for which the applicant may be eligible. 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types* describes the rules for establishing this date.

(B) End Date of Coverage. MassHealth benefits terminate no sooner than 10 days from the date of termination notice unless the MassHealth Member timely files an appeal and requests continued MassHealth benefits pending such appeal. MassHealth will extend coverage to the end of the month only for those individuals whose MassHealth eligibility is terminated and who become eligible for the Premium Tax Credit (PTC). If the effective date of the termination is on or before the 15th of the month, MassHealth coverage will end on the last day of that month. If the effective date of the termination is after the 15th of the month, MassHealth coverage will end on the last day of the following month.

502.007: Continuing Eligibility ~~Review~~

(A) Annual Renewals. The MassHealth agency reviews eligibility ~~at least~~ once every 12 months. Eligibility may also be reviewed as a result of a member's change in circumstances, or a change in MassHealth eligibility rules, or as a result of a member's failure to provide verification of immigration status, breast or cervical cancer status or HIV-positive status. The MassHealth agency updates ~~the case file~~ eligibility based on information received as a result of such review. The MassHealth agency reviews eligibility:

(1) by information matching with other agencies, health insurance carriers, and information sources;

(2) through a written update of the member's circumstances on a prescribed form; ~~or~~

(3) through an update of the member's circumstances in person, by telephone, or on the MAHealthConnector.org account; or

(4) based on information in the member's case file.

(B) Eligibility Determinations. The MassHealth agency determines, as a result of this review, if:
(1) the member continues to be eligible for the current coverage type;
(2) the member's current circumstances require a change in coverage type, premium payment, or premium assistance payment; or
(3) the member is no longer eligible for MassHealth.

(C) Eligibility Reviews. MassHealth reviews eligibility in the following ways.
(1) Automatic Renewal. Households whose continued eligibility can be determined based on electronic data matches with federal and state agencies will have their eligibility automatically renewed.
(a) The MassHealth agency will notify the member if eligibility has been reviewed using the automatic renewal process. The notice will include information about the data that was received through electronic data matches and used to determine continued eligibility.
(b) If the member's coverage type changes to a more comprehensive benefit, the start date for the new coverage is the date of the written notice, except that premium assistance payments under MassHealth Family Assistance begin in the month of the MassHealth agency's eligibility determination or in the month that the insurance deduction begins, whichever is later in accordance with 130 CMR 506.012(F)(1)(d).
(2) Prepopulated Review Form. If the individual's continued eligibility cannot be determined based on reliable information contained in their account or electronic data match with federal and state agencies, a prepopulated eligibility review form must be completed.
(a) The MassHealth agency will notify the member of the need to complete the prepopulated review form.
(b) The member will be given 45 days to return the paper prepopulated review form, log onto his or her MAHealthConnector.org account to complete the review online, or call the MassHealth agency to complete the review telephonically.
(i) If the review is completed within 45 days, eligibility will be determined using the information provided by the individual with verification confirmed through electronic data matches if available.
(ii) If the review is not completed within 45 days, eligibility will be terminated within 14 days from the date of determination.
(iii) If the individual submits the prepopulated review within 90 days of the termination date and is determined eligible for a MassHealth benefit, eligibility for that benefit is the date of the termination.
(iv) If the prepopulated review is returned, but the required verifications are not submitted with the form, a second 90-day period starts on the date that the prepopulated form is returned.
(v) If the prepopulated review is not submitted within 90 days of the previous termination date, a new application is required.
(c) If the member's coverage type changes, the start date for the new coverage type is determined as follows.
(i) If the member's coverage type changes, the start date for the new coverage type is effective as of the date of the written notice.
(ii) However, premium assistance payments under MassHealth Family Assistance begin in the month of the MassHealth agency's eligibility determination or in the month the insurance begins, whichever is later in accordance with 130 CMR 506.012(F)(1)(d).
(3) Periodic Data Matches. The MassHealth agency matches files of MassHealth members with other agencies and information sources as described in 130 CMR 502.004 to update or verify eligibility,
(a) If the electronic data match indicates a change in circumstances that would result in potential reduction or termination of benefits, the MassHealth agency will notify the member of the information that was received through the data match and require the member to respond within 30 days of the date of the notice.
(i) If the member responds within 30 days and confirms the data is correct, eligibility will be determined using the confirmed data from the electronic data match.
(ii) If the member responds within 30 days and provides new information, eligibility will be determined using the information provided by the member. Additional

verification from the member will be required.

(iii) If the member does not respond within 30 days, eligibility will be determined using the data from the electronic data match.

(b) If the electronic data match indicates a change in circumstances that would result in an increase or no change in benefits, the MassHealth agency will notify the member of the information that was received through the data match and automatically update the case using the information received from the electronic data match and redetermine eligibility. The effective date of the change is the date of the redetermination of eligibility.

~~(C) The MassHealth agency does not notify the member if there is no change in the member's coverage type, premium payment, or premium assistance payment.~~

~~(D) If the member's coverage type changes, the start date for the new coverage type is determined as follows.~~

~~(1) If the new coverage type provides more comprehensive benefits to the member, coverage is effective as of the date of the written notice with the following exceptions.~~

~~(a) Coverage for the purchase of medical benefits under Basic is effective upon the member's enrollment with a MassHealth managed care provider.~~

~~(b) Coverage for the purchase of medical benefits under Essential is effective upon the member's enrollment in the Primary Care Clinician (PCC) Plan. MassHealth Essential members who are aliens with special status are afforded eligibility under MassHealth Limited pursuant to 130 CMR 505.007(E).~~

~~(c) Coverage for premium assistance under Basic and Essential is effective in the calendar month following the date of the written notice. MassHealth Essential members receiving premium assistance who are aliens with special status are afforded eligibility under MassHealth Limited pursuant to 130 CMR 505.007(E).~~

~~(d) Premium assistance payments under Family Assistance begin in the month of the MassHealth agency's eligibility determination, or in the month the insurance deduction begins, whichever is later.~~

~~(2) If the new coverage type provides less comprehensive benefits to the member, coverage is effective subsequent to the member's receipt of a timely written notice in accordance with 130 CMR 610.015.~~

~~(E) If the member fails to provide a written update of his or her circumstances within 45 days of the MassHealth agency's request, MassHealth coverage is terminated, except as provided in 130 CMR 502.007(G). If the member subsequently submits a written update, the MassHealth agency determines his or her eligibility as of the date the written update is received. If the applicant is determined eligible, the medical coverage date is established in accordance with the rules in 130 CMR 502.006.~~

~~(F) If the member fails to provide verification of information within 60 days of the MassHealth agency's request, MassHealth coverage is terminated.~~

~~(1) Except as provided at 130 CMR 501.003(E), if required verifications are received within one year of receipt of the previous MBR or written update on a prescribed form, coverage is reinstated 10 days before receipt of the verifications unless the member is determined eligible for the purchase of medical benefits under MassHealth Basic or Essential, or premium assistance under Basic, Essential, or Family Assistance. For those members, the medical coverage date is established in accordance with the rules in 130 CMR 502.006. Coverage under Essential is also subject to the funding restrictions described at 130 CMR 505.007.~~

~~(2) If required verifications are not received within one year of receipt of the previous MBR or written update on a prescribed form, a new MBR must be completed.~~

~~(G) The MassHealth agency matches files of MassHealth members who appear on the Department of Revenue (DOR) records as "new hires" or for whom DOR has received quarterly wage reporting information. If the DOR records contain data that is inconsistent with information previously recorded on the MassHealth case file, the MassHealth agency sends a notice with a Job Update form to the MassHealth member whose name appears on the DOR file. The MassHealth agency must receive the completed Job Update form within 30 days from the date on the notice. If the Job Update form is not received within the 30-day period, MassHealth coverage for the family group is terminated. If the member submits a written update after the end of the 30-day period, the MassHealth agency determines family group eligibility as of the date the written update is received and the start date of MassHealth coverage is established in accordance with 130 CMR 502.006.~~

502.008: Notice

(A) MassHealth provides ~~A~~all applicants and members ~~receive~~ a written notice of the eligibility determination for MassHealth. The notice contains an eligibility decision for each member ~~of the family group~~ who has requested MassHealth, and either provides information so the applicant or member can determine the reason for any adverse decision or directs the applicant or member to such information.

(B) Members also receive a notice, in accordance with 130 CMR 610.015: *Time Limits*, of any loss of coverage, or any changes in coverage type, premium, or premium assistance payments.

(C) The notices described in 130 CMR 502.008(A) and (B) provide information about the applicant's and member's right to a fair hearing, with the exception of notices about hospital-determined presumptive eligibility, as described in 130 CMR 502.003(G), and notices about federal or state law requiring an automatic change adversely affecting some or all members, as described in 42 CFR 431.220(b)~~eligibility for presumptive coverage as described at 130 CMR 505.002(C)(3) and 505.005(C)(2), and for prenatal coverage as described at 130 CMR 505.003.~~ Information about the appeal process is found at 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

502.009: Voluntary Withdrawal

The applicant or ~~eligibility~~ authorized representative may voluntarily withdraw his or her ~~request~~ application for MassHealth.

502.010: Issuance of a MassHealth Card

(A) The MassHealth agency issues a MassHealth card to new members, with the exception of those who receive premium assistance under MassHealth Small Business Employee Premium Assistance as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*.

~~(1) MassHealth Family Assistance for children, as described at 130 CMR 505.005(B);~~
~~(2) MassHealth Family Assistance for adults, as described at 130 CMR 505.005(C);~~
~~(3) MassHealth Basic, as described at 505.006(C); or~~
~~(4) MassHealth Essential, as described at 505.007(C).~~

(B) A temporary card may be issued to a member if there is an immediate need.